

Department of Human Services
Center for Adult Health
600 New London Avenue
Cranston, Rhode Island 02920
462-2356
462-2183

RHODE ISLAND ORGAN TRANSPLANT FUND
APPLICATION FOR BENEFITS

IMPORTANT:

Before completing this application, refer to the Eligibility Brochure. Be sure to answer each item on both sides of this form.

A. APPLICANT IDENTIFICATION:

1. Name _____ Telephone _____

Transplant Recipient if other than applicant _____

2. Address _____
(City/Town) (Zip)

3. Date of Birth _____ Sex _____ Marital Status _____

4. Is the transplant recipient a Rhode Island Resident?

Yes _____ No _____ If yes, how long? _____

5. Dependents:

NAME

RELATIONSHIP

DATE OF BIRTH

SPOUSE

B. CLAIM INFORMATION:

1. Diagnosis _____
2. Type of Transplant _____
Actual or estimated transplant date _____
3. Name and address of actual or anticipated transplant center

4. List all health insurance plans, including Medicare and Medicaid covering the transplant recipient:

Insurer	Covered Member	Policy No.	Effective Date
_____	_____	_____	_____
_____	_____	_____	_____
5. Has the transplant recipient or any family member applied for, enrolled in or been declared eligible for any state or federal program which pays for or provides organ transplant services?
Yes _____ No _____
If yes, please explain:

6. List approximate current family income from all sources below:

Person	Source	Monthly Amount
_____	_____	_____
_____	_____	_____

I hereby certify the accuracy of the information supplied herein and authorize any insurance company, prepayment organization, non-profit hospital and medical corporation, employer, hospital, or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under the Rhode Island Organ Transplant Fund. I permit a copy of this authorization to be used in place of the original. I understand that failure to provide information which is true, correct and complete is in violation of the Laws of the State of Rhode Island and Providence Plantations.

Date

Signature of Applicant